CONNECTICUT NURSES' ASSOCIATION

377 Research Parkway 2D
Meriden, CT 06450
203-238-1207
FAX (203) 238-3437
www.ctnurses.org

TESTIMONY RE: PROPOSED BILL NO. 5625 AN ACT CONCERNING THE DEFINITION OF SURGERY

Public Health Committee
February 23, 2015

Good Day, Senator Gerrantana, Representative Ritter and members of the Public Health Committee.

Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA), the professional organization for registered nurses in Connecticut. I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University.

I bring forth strong concerns over the Language in PROPOSED BILL NO. 5625, AN ACT CONCERNING THE DEFINITION OF SURGERY.

As a result of multiple requests from multiple groups of providers the co-chairs of Public Health, Senator Harris and Representative Ritter made a request to the Program and Investigations Committee to review the current issues surrounding Scope of Practice definitions nationally. Based on that review, recommendations were made to the Public Health Committee and resulted in a "Legislated Scope of Practice Process" that has been implemented through the Department of Public Health. The process provides an

objective review of the research related to the quality and safety of practice making the request. The Scope review process is work intensive but to date has proved to be effective.

The request of **PROPOSED BILL NO. 5625 AN ACT CONCERNING THE DEFINITION OF SURGERY** has not been through a Scope of Practice review. A request was made in October of 2013 but the review did not occur in 2014. Therefore this request bypasses the legislated process recommended by this committee and signed into law in this state.

It is no surprise to the Health Care Community that legislation would be proposed to clarify the definition of surgery.

> The longstanding philosophy behind this approach is that physician scope of practice is all encompassing, and other healthcare providers must **"carve out"** some aspect(s) of medical practice as their scope of practice. In addition to exceptions in the medical practice act, most healthcare providers, including nurses, who are licensed or otherwise recognized under state law typically have their own statutes and regulations that set forth their scopes of practice. By the very nature of the unlimited practice of medicine, the scopes of practice of other healthcare providers are a subset of the scope of practice of medicine. (Saffriet, 1992)
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> The American Medical Association (AMA) at its Annual Meeting discussed the movement to legislate a statutory definition of surgery at the state level as a methodology to limit non-physicians' attempts to expand their scope into the performance of surgery. (AMA)
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> "The AMA writes in their publications this current legislation is directed toward defeating legislation that expands "non surgeon" health care practitioners' scope of practice. Working in collaboration with a larger coalition of state medical societies and national surgical specialty societies is essential to ensure that health care professionals performing surgical procedures have the proper education, licensing, and training to do so." It has become an all-too-common occurrence in state legislatures for one group of licensed health care professionals to seek modifications in their licensing acts in an effort to expand their scope of practice.

The aforementioned issues have been under assault for as many years as I can remember. The concerns discussed were evident in our negotiations with the Connecticut Sate Medical Society (CSMS) as far back as 1997 when we started negotiating revisions to the Nurse Practice Act, which were adopted in 1999. At that time we made many compromises.

However, the recent report from the Institute of Medicine ("IOM") has added fuel to the fire at the national, regional and state level. The IOM made the following recommendations

In 2008, The Robert Wood Johnson Foundation (RWJF) and the IOM launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing. Through its deliberations, the committee developed four key messages:

1) Nurses should practice to the full extent of their education and training.
2) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3) Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4) Effective workforce planning and policy making requires better data collection and information infrastructure.

The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. **However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role**. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes. (Robert Wood Johnson, IOM Report)

The second concern driving this issue of full scope of practice is access to care. The increasing need for providers of health care is a growing problem the workforce in Connecticut is aging. The issues will reimbursement and malpractice have served

to change the demographics of the work force and many professions are facing new challenges'

In a recent article in the Economist the changing role of the Doctor was explicated along with the changing health care environment and the implications for practice.
"The past 150 years have been a golden age for doctors. In some ways, their job is much as it has been for millennia: they examine patients, diagnose their ailments and try to make them better. Since the mid-19th century, however, they have enjoyed new eminence. The rise of doctors' associations and medical schools helped separate doctors from quacks. Licensing and prescribing laws enshrined their status. And as understanding, technology and technique evolved, doctors became more effective, able to diagnose consistently, treat effectively and advise on public-health interventions—such as hygiene and vaccination—that actually worked.
This has brought rewards. In developed countries, excluding America, doctors with no specialty earn about twice the income of the average worker, according to McKinsey, a consultancy. **America's specialist doctors earn ten times America's average wage. A medical degree is a universal badge of respectability. Others make a living. Doctors save lives, too.**
With the 21st century certain to see soaring demand for health care, the doctors' star might seem in the ascendant still. By 2030, 22% of people in the OECD club of rich countries will be 65 or older, nearly double the share in 1990. China will catch up just six years later. About half of American adults already have a chronic condition, such as diabetes or hypertension, and as the world becomes richer the diseases of the rich spread farther. In the slums of Calcutta, infectious diseases claim the young; for middle-aged adults, heart disease and cancer are the most common killers. Last year the United Nations held a summit on health (only the second in its history) that gave warning about the rising toll of chronic disease worldwide.
But this demand for health care looks unlikely to be met by doctors in the way the past century's was. For one thing, to treat the 21st century's problems with a 20th-century approach to health care would require an impossible number of doctors. For another, caring for chronic conditions is not what doctors are best at. For both these reasons doctors look set to become much less central to health care—a process which, in some places, has already started.

In 2010 America's respected Institute of Medicine (IOM) called for nurses to play a greater role in primary care. Among other barriers, nurses face wildly different constraints from one state to another. But any change will first require swaying the doctors. The American Medical Association, the main doctors' lobby, greeted the IOM's report with a veiled snarl. "Nurses are critical to the health-care team, but there is no substitute for education and training," the group said in a statement.

As doctors become scarcer and health costs continue to rise, more and more systems will seek to innovate, and the successes they have will become ever more widely known.

Resources are slowly being reallocated. Nurses and other health workers will put their training to better use. Devices will bolster care in ways previously unthinkable. Doctors, meanwhile, will devote their skill to the complex tasks worthy of their highly trained abilities. Doctors may thus lose some of their old standing. But patients will clearly win.
http://www.economist.com/node/21556227?fsrc=email_to_a_friend

Conclusions: The issues that surround this request are evident. Change is always difficult. In this case it is difficult for the Medical Providers to deal with changing traditional roles. It is also challenging for "Government" on all levels to deal with a barrage of requests that call for changes in scope of practice. This challenge is going to continue as the "Environment" and the "Demand for Health Care" increases exponentially due to aging, chronic disease and an imbalance between supply and demand as the demographics of the health care providers' workforce change.(age, retirement etc.)

What we should be concentrating on is creating a health care system that functions at full capacity, utilizes educated providers as we create a system of health care that emphasizes the "Team Approach to the Provision of Primary Community Health" that holds all primary providers accountable for the care that they provide in these settings. We need to cultivate and utilize technology appropriately, we need to recognize the expertise of our health provider retiree's, we need to focus on prevention, we need to collaborate instead of competing.

There is a place in the evolving health care system for all providers but what we must remember is as the demand increases roles will change. It is our responsibility to provide safe, high quality across the spectrum and we must be accountable to assuring the public we serve that Connecticut via the Department of Public Health reviews

scopes, writes regulation and monitors through appropriate mechanisms the outcomes of the care provided.

The Connecticut Nurses Association does not support **PROPOSED BILL NO. 5625 AN ACT CONCERNING THE DEFINITION OF SURGERY** and recommends the issue be addressed through a formal scope review process.

I thank you for this opportunity to present testimony.

Mary Jane M Williams PhD., RN

Chair, Government Relations, Connecticut Nurses Association

Professor Emeritus Central Connecticut State University

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- What is the applicability of the surgery definition? Is it limited to the medical practice act, or does it apply more broadly to provisions of state law that also apply to providers other than physicians?

- If the definition applies to the medical practice act alone, is there sufficient exception/exemption language to protect nursing/CRNA practice? For example, is the exception broad (e.g., a blanket exception for the practice of nursing, or for any licensed healthcare provider practicing within his or her scope of practice), or limited (e.g., an exception for the practice of nursing that occurs under the supervision and responsibility of a licensed physician)? A broad exception without reference to physician involvement potentially provides a stronger argument that a provider who is not a physician is not performing "surgery."

- Is CRNA or nursing scope of practice defined in the nurse practice act or board of nursing rules? Does the CRNA or nursing scope of practice provide any additional support for the argument that elements of a broad surgery definition are already within CRNA or nursing scope of practice?

- If the state association decides to take a position concerning legislation that includes a broad definition of surgery, consider contacting nursing and other provider groups (e.g., other APNs, optometrists, podiatrists) that could potentially be affected.

Testimony or comments from a coalition of providers who would be affected by a broad "surgery" definition may be beneficial, since legislation of this type has the potential to affect so many providers.

Trend Alert: "Surgery" definition:

Legislation has been introduced in several states in recent years to define "surgery," usually within the state's medical practice act. The definitions proposed in various states have been similar, but not identical, and have been extremely broad. Because there is some variation in the proposed definitions, it is not clear whether there is a "model" being promoted by a particular organization. Beginning in the 2009 legislative session, some proposed state definitions have been nearly identical to the definition adopted in June 2007 by the American Medical Association (AMA) House of Delegates (see excerpt below) from the American College of Surgeons definition. There does not appear to be a similar definition of "surgery" in the Federation of State Medical Boards' model medical practice act, which is available on the FSMB website at http://www.fsmb.org/pdf/GRPOL_essentials.pdf.

That chapter 370 of the general statutes be amended to define 2 "surgery" to mean: The structural alteration of the human body by 3 incision or destruction of tissue or the diagnostic or therapeutic 4 treatment of conditions or disease processes using any instrument 5 causing localized alteration or transposition of live human tissue, 6 including, but not limited to, lasers, ultrasound, ionizing radiation, 7 scalpels, probes and needles, used to cut, burn vaporize, freeze, suture, 8 probe, or otherwise alter by mechanical, thermal, light-based, 9 electromagnetic, or chemical means, or manipulation by closed 10 reductions for major dislocations or fractures, or the injection of 11 diagnostic or therapeutic substances into body cavities, internal 12 organs, joints, sensory organs and the central nervous system.